DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC # 3 acceptable

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445304	A. BUILDING _____ B. WING _____	07/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDRIDGE HEALTH AND REHAB CTR	456 WAYNE AVENUE CROSSVILLE, TN 38555

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F 000	INITIAL COMMENTS During the annual recertification survey conducted at Wyndridge Health and Rehabilitation on 7/12/15-7/14/15, complaints #34858, #35056, #35856, #36024, and #36232 were investigated. No deficiencies were cited under 42 CFR PART 483, Requirements for Long Term Care, in relation to the complaints.	F 000	This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid Requirements and Tennessee requirements when necessary. This corrective action plan is submitted as required under the regulations that governing participation in the Medicare/Medicaid programs. It should not be construed as an admission of any alleged findings or conclusions of the state survey agency.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview, the facility failed to complete a pre-restraining assessment for 1 resident (#72) of 16 residents in restraints. The findings included: Review of the facility policy Use of Chemical/Physical Restraints (undated) revealed, "...Procedure: Complete a Pre-Restraint Assessment prior to administration of a restraint. Assess for an appropriate, least restrictive and most effective device for resident...Documentation should be made of the behaviors leading to the use of the restraint..." Medical record review revealed Resident #72 was admitted to the facility on 2/20/13 with diagnoses including Hemiplegia, Dementia, Delusional	F 221	Resident #72 on 7-14-15 a complete Pre-restraint assessment was done by day shift charge nurse. On 7-15-15, Risk Manager audited resident Charts that required restraints to ensure Accurate and complete documentation. July 28, 2015,The Risk Manager in-serviced the staff on the completion of the pre-restraint assessment prior to the administration of the restraint, using the least restrictive and most effective device for the resident and the required documentation leading to the use of the restraint. (See Exhibit 1) When a restraint is ordered the Unit Manager will ensure restraint assessment is complete until further notice. Restraints are discussed in weekly meetings. With DON, ADON, Unit Managers and Risk Manager.	07/28/2015

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brian Brewer LPN BA, LNHA — Asst Administrator — 8-24-15

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

AUG 26 2015

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F 221	Continued From page 1 Disorder, Difficulty Walking, and Muscle Weakness. Medical record review of the Physicians Orders dated July 2015 revealed "...Lap Belt in place when up in wheelchair for safety..." with a start date of 10/29/14. Medical record review of the Pre-Restraining Assessment document (undated) revealed the document had not been signed, and did not identify the type of device or medical symptom that warranted the use of the restraint. Observation of Resident #72 seated in the wheelchair on 07/12/15 at 8:20 AM, in the A-Wing dining area, revealed a lap belt restraint device in use. Interview with the Director of Nursing (DON) on 7/14/15 at 9:45 AM, in her office, confirmed the DON expected the Pre-Restraining Assessment document to be completed prior to the application of the lap belt restraint.	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on review of a CNA (Certified Nursing Assistant) Candidate Handbook, observation, and interview, the facility failed to promote dignity in	F 241		

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F 241	Continued From page 2 dining for 7 residents of 11 observed in 1 of 3 dining rooms observed. The findings included: Review of the CNA Candidate Handbook dated 2/1/15, revealed, "...Feeding the Dependent Resident...sit down in a chair facing the resident while feeding resident..." Observation of breakfast service on 7/12/15 at 8:30 AM, in the 200 Dining Room, revealed CNA #1 feeding 7 dependent residents. Further observation revealed CNA #1 standing and moving between the residents to feed the residents. Interview with CNA #1 on 7/12/15 at 9:30 AM, in the 200 Hallway, confirmed, "...if I had sat down, I would have neglected somebody..." Interview with the Director of Nursing (DON) on 7/13/15 at 7:35 AM, in the DON office, confirmed CNA #1 was to be seated across from the residents and the facility failed to assist the residents with dignity in dining.	F 241	On July 31st 2015The Assistant Director of Nursing Completed an In-service instructing the staff on dining room dignity and sitting down in the chair facing the resident and not standing while feeding the resident. (See Exhibit 2) The staffing has been adjusted in all three dining room via staffing coordinator to accommodate census and to accommodate the amount of dependent assist-feed residents The Charge nurses will monitor the dining Rooms for dignity issues weekly Dependent assist-feed residents are Discussed in the Nutritionally at Risk Weekly meeting attended by DON, ADON, Unit Managers, Risk Manager, Dietary Manager, Speech Therapy and Wound Care. Any changes as a result of meeting are communicated to Staffing coordinator.	07/31/2015
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		

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F 312	Continued From page 3 Based on review of facility policy, medical record review, observation, and interview, the facility failed to assist 1 resident (#92) with oral care for 33 residents reviewed. The findings included: Review of the facility policy Oral Care, undated, revealed "...cleanse...resident's teeth and mouth...lessening the chance of infection..." Medical record review revealed Resident #92 was admitted to the facility on 6/16/15 with diagnoses including Chronic Obstructive Pulmonary Disease, Prolonged Depression, Epilepsy, and Muscle Weakness. Review of the Care Plan, Self-Care Deficit, dated 6/16/15, revealed "...assist...with oral care a.m., p.m., and prn [as needed]..." Medical record review of the 14 day Minimum Data Set (MDS) dated 6/30/15, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 (cognitively intact). Further review revealed the resident's function related to personal hygiene including brushing teeth was "limited assist". Observation of Resident #92 on 7/13/15 at 2:15 PM, in the resident's room, revealed the resident did not have teeth or dentures. Interview with Resident #92 on 7/13/15 at 2:15 PM, in the resident's room, revealed the resident had not had oral care on 7/12/15 or 7/13/15. Interview with Certified Nursing Assistant (CNA) #2 on 7/13/15 at 2:30 PM, in the resident's room,	F 312	Resident #92 on 7-13-15 was evaluated and received oral care via day shift charge nurse. On 7/15/15 DON evaluated CNTs assessment Sheets to verify oral care complete for appropriate residents. On July 27th, 2015The Assistant Director of Nursing Completed an in-service for the staff on oral care and its importance. (See Exhibit 3) Residents with assist needed for oral care will be noted on the CNTs assignment sheets. Care plans to cue them of assist needed. Charge nurse to monitor self care for all residents for oral care daily and as needed. Care plans will be adjusted or updated as needed for specific frequencies of oral care.	7/27/15

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F 312	Continued From page 4 confirmed the CNA was assigned to the resident on 7/12/15 and 7/13/15. Continued interview confirmed CNA #2 had not assisted Resident #92 with oral care on 7/12/15 or 7/13/15 "...I was too busy..." Interview with the Unit Manager/Registered Nurse (UM/RN) on 7/13/15 at 2:30 PM, in the 200 Unit Manager office, confirmed the facility failed to assist Resident #92 with oral care "...we need to do more..."	F 312		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, review of manufacturer's recommendations, medical record review, observation, and interview, the facility failed to ensure proper application of a restraint in accordance with manufacturer's recommendations for 3 residents (#72, #61, #112) of 5 observed for accidents. The findings included: Review of the facility policy Use of Chemical/Physical Restraints, no date, revealed "...Apply restraint per manufacturer's guidelines."	F 323		

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F 323	Continued From page 5 Review of manufacturer's application instructions Lap Belt/Padded Lap Belt, 2009, revealed "...Lay the lap belt across the patient's thighs. Bring the ends of the connecting straps down at a 45 degree angle between the seat and the wheelchair sides. Criss-cross the straps behind the chair and draw them around the opposite side kick spurs..." Medical record review revealed Resident #72 was admitted to the facility on 2/20/13 with diagnoses including Hemiplegia, Dementia, Delusional Disorder, Difficulty Walking, and Muscle Weakness. Medical record review of the Physicians Orders dated July 2015 revealed "...Lap Belt in place when up in wheelchair for safety..." with a start date of 10/29/14. Observation of Resident #72 on 07/12/15 at 8:20 AM, in the A-Wing dining area, revealed the resident had a lap restraint applied. Further observation revealed the lap restraint straps were threaded between the seat and the side panel of the wheelchair, criss-crossed underneath the seat of the chair with the straps attached to the opposite side anti-tipper bars behind the wheelchair. Further observation revealed there was a belt wrapped around the anti-tipper bars below the restraint straps, which would prevent the straps from being removed without first removing the belt. Observation of Resident #61 on 07/12/15 at 8:20 AM, who was sitting with Resident #72 in the A-Wing dining area, revealed the resident also had a lap restraint applied. Further observation	F 323	Resident #72 and #61 on 7-12-15was evaluated and lap belt was removed and replaced according to manufactures guidelines via day shift charge nurse. Resident #112 on 7-13-15 was evaluated And lap belt was removed and replaced According to manufactures guidelines via Day shift charge nurse. On 7-14-15 Risk Manager observed Residents Requiring lap belts to ensure proper application. On July 15th, 2015The Risk Manager in-serviced the staff on the proper application of a lap belt according to the manufacturers recommendation. (See Exhibit 4) The charge nurse of the residents requiring a restraint will check for placement and application every shift. The Risk Manager will weekly check to ensure restraints are applied correctly until further notice. Residents currently utilizing restraints and/or residents demonstrating potential need for restraints are discussed in weekly Restraints meetings with DON, ADON, Unit Managers and Risk Manager. Change nurse communicates to unit manager Possible need for restraint and unit manager brings Recommendation to committee. Committee refers to Physical therapy for alternative options. Restraint Meetings will be held until further notice.	07/15/2015

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F 323	Continued From page 6 revealed, like resident #72, the lap restraint straps were threaded between the seat and the side panel of the wheelchair, criss-crossed underneath the seat of the chair with the straps attached to the opposite side anti-tipper bars behind the wheelchair. Interview with Licensed Practical Nurse (LPN) #1 on 07/12/15 at 8:30 AM, revealed, "...not sure if applied correctly will have to check policy on application." Continued interview with LPN #1 confirmed the belt, which was wrapped around the anti-tipper bars below the restraint straps for Resident #72, was incorrectly applied and would prevent the restraint from being removed quickly and easily. Observation of Resident #112 on 7/13/15 at 8:29 AM, in the A-wing dining area, revealed the resident had a lap belt in place. Further observation revealed the left side strap of the lap belt was between the seat and the side panel and underneath the wheel chair. The right side strap was placed under the wheelchair arm rest, over the top of the side panel, and across the back of chair. The straps criss-crossed underneath the wheelchair seat and were attached to the opposite side anti-tipper bars behind the wheelchair. Observation of Resident #61 on 07/13/15 at 2:45 PM, in the A-wing dining area, revealed the resident had a lap restraint applied. Further observation revealed the lap restraint straps were placed between the seat and the side panel of the wheelchair, criss-crossed underneath the wheelchair, and attached to the opposite side anti-tipper bars behind the wheelchair.	F 323		

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F 323	Continued From page 7 Interview with the Director of Nursing on 07/13/15 at 2:54 PM, in the A-Wing dining area, confirmed the lap belts were incorrectly applied to the residents' wheelchairs.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation, and interview, the facility failed to maintain a sanitary kitchen for kitchen equipment, prepared foods, and food storage in the dietary department having the potential to affect 108 of 120 residents in the facility. The findings included: Review of the facility policy Cleaning Schedule/Cleaning Equipment, undated, revealed "...follow cleaning schedule...vents...oven...bakers rack...back shelf..." Review of the facility policy, Proper Disposal of Food Items, undated, revealed "...date the item...discard date...no more than 48 hrs. [hours]..."	F 371		

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F 371	Continued From page 8 Review of the facility policy, Thermometers Cooler and Freezer, undated, revealed "...thermometers are checked three times a day and documented..." Observation of the kitchen with Dietary Aide #1 on 7/12/15 at 8:45 AM, revealed a 3 tier bakers rack stored with clean pots, pans, and utensils. Continued observation revealed directly across from the bakers rack, in a space that would allow 1 person to pass through, was the back of the exposed double oven, with a thick accumulation of dust debris on the coils and exhaust, grease on the duel shelves, and 2 insect monitors on the bottom shelf with 1 visible dead bug. Observation with Dietary Aide #1 on 7/12/15 at 8:52 AM, during the breakfast service, revealed an opened food temperature log book on top of a toaster with brown crumbs. Observation with the Dietary Manager (DM) on 7/12/15 at 9:00 AM, during breakfast service in the kitchen, revealed 2 trays of the following: 11 orange juices, 3 cranberry juices, 2 grape juices, 4 tomato juices, and 4 prune juices. Continued observation revealed the 2 trays with the poured juices sitting in a pool of mixed spilled juices. Observation with the DM on 7/12/15 at 9:05 AM, of the walk-in refrigerator, revealed 2 undated tubs of prepared pistachio pudding, 1 undated carton of pickled beets, 2 blocks of open to air American cheese, 1 tub of cooked cheese biscuits, 1 container of cheese manicotti dated "7/8", and a personal lunch box on the top shelf next to the prepared foods. Further observation revealed a duel cooling fan with dust debris.	F 371	On 7-12-15, Dietary staff thoroughly cleaned Kitchen area behind double ovens. On 7-12-15 dietary manager placed notebooks in proper Storage area. On 7-12-15 Dietary Manager Instructed dietary staff to clean Spilled juice from trays prior to sending to sending to floor. This instruction came after initial trays were on the floor. On 7-12-15 undated food and open to Air Articles and outdated food was thrown away Immediately via dietary staff. On 7-12-15 personal lunch box was moved to Employee break room via dietary staff. 0n 7-12-15 dueling fan with dust debris Was cleaned via dietary staff. On 7-12-15 sugar bin was cleaned via Dietary staff On 7-12-15 a thermometer was placed into Walk-in freezer via dietary staff.	

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F 371	Continued From page 9 Continued observation revealed 29 shelled eggs sitting in an egg container under the blowing fan. Observation with the DM on 7/12/15 at 9:15 AM, of the sugar bin, revealed a line of purple discoloration saturated into the sugar. Observation with the DM on 7/12/15 at 9:20 AM, of the walk-in freezer, revealed no thermometer in the freezer. Continued observation revealed a tub of vanilla ice cream with an open lid. Interview with the DM on 7/12/15 at 9:25 AM, in the kitchen, confirmed the facility failed to clean the back of the exposed oven, to prepare sanitary juices, to prevent facility manuals being placed on top of in use kitchen equipment, to date prepared foods, to monitor expired foods, to store personal food with resident food, to clean a duel cooling fan, to maintain a sanitary sugar bin, to secure the lid on the ice cream container, and to monitor a freezer thermometer to maintain sanitary conditions in the kitchen.	F 371	On July 28th, 2015, the Dietary Manager in conjunction with Registered Dietitian completed an in-service instructing the staff on the following policies: - proper cleaning of the ovens and fans - serving juices from clean trays - proper storage of manuals and notebooks - monitoring thermometers in cooler and freezer - cleaning of food storage bins - storage of personal food items - dating and discarding food items The Dietary Manager updated the daily cleaning schedule. The designee will monitor and initial three times a week that tasks have been completed accordingly. The Dietary Manager updated the cooler and freezer temperature logs. (See Exhibit A) The Dietary Manager will monitor sign-in sheets for completion and will also do random walk thrus for cleanliness and organization until further notice.	07/28/2015